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# COUNTY OF LOS ANGELES
# DEPARTMENT OF AUDITOR-CONTROLLER

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September 29, 2010

TO: Supervisor Gloria Molina, Chair
Supervisor Mark Ridley-Thomas
Supervisor Zev Yaroslavsky
Supervisor Don Knabe
Supervisor Michael D. Antonovich

FROM: Wendy L. Watanabe
Auditor-Controller

SUBJECT: **STATUS REPORT - REQUEST FOR EXTENSION FOR REVIEW OF PHYSICIAN INDIGENT CARE REIMBURSEMENT PROGRAM (Board Agenda Item 17, February 16, 2010)**

At the February 16, 2010 meeting, your Board instructed the Auditor-Controller, in consultation with various departments, including County Counsel, the Emergency Medical Services (EMS) Commission, the Hospitals and Health Care Delivery Commission and the Physician Reimbursement Advisory Committee, to review the Physician Indigent Care Reimbursement Program (PSIP) and submit a progress report in 90 days.

We have completed our review. However, one of the commissions has requested that we wait to issue our report until after the commission's next meeting in November 2010, so that the commission can review and discuss our draft report. As a result, we expect to issue our report to your Board no later than December 15, 2010.

Please call me if you have any questions, or your staff may contact Jim Schneiderman at (213) 253-0101.

WLW:MMO:JLS:mwm

c: William T Fujioka, Chief Executive Officer
Department of Health Services
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March 11, 2011

TO: Supervisor Michael D. Antonovich, Mayor
Supervisor Gloria Molina
Supervisor Mark Ridley-Thomas
Supervisor Zev Yaroslavsky
Supervisor Don Knabe

FROM: Wendy L. Watanabe
Auditor-Controller

SUBJECT: **DEPARTMENT OF HEALTH SERVICES – PHYSICIAN SERVICES FOR INDIGENTS PROGRAM (PSIP) (Board Agenda Item 17, February 16, 2010)**

In February 2010, the Board of Supervisors (Board) instructed the Auditor-Controller (A-C), in consultation with affected departments and commissions, to review the Department of Health Services' (DHS) Physician Services for Indigents Program (PSIP or Program).

DHS established PSIP in 1987 to reimburse non-County physicians for emergency medical services provided to uninsured indigent patients who do not pay their bill. DHS' Emergency Medical Services (EMS) Agency and Health Services Administration administer PSIP, and contract with a Third-Party Administrator to pay physician claims based on a reimbursement rate approved by the Board. DHS' estimated FY 2009-10 PSIP budget was approximately $22 million.

Your Board instructed the A-C to conduct a policy and operational review of the PSIP program, specifically in the areas of: 1) DHS paying physicians promptly, fairly and efficiently; 2) PSIP transparency; and 3) preserving the County's emergency care safety net. The following is a brief summary of the results of our review:

## Paying Physicians

PSIP reimbursement rates have been reduced because of a significant reduction in State funding, while the number of PSIP physicians and claims have increased.

Specifically, the State has eliminated all $8.8 million of Emergency Medical Services Appropriation (EMSA) funding. As a result, DHS and the Board reduced the PSIP reimbursement rate by 33%, which resulted in lower payments for physician claims. We have recommended that DHS continue to work with other counties and interested parties to get the State to restore funding.

The Board also asked us to look at whether PSIP payments are "inherently unfair". We noted that PSIP physicians are currently paid an average of $48 per claim. This is substantially less than Medicare and Medi-Cal pay. For example, Medicare would have paid the physicians an average of $73 per claim. While we cannot assess whether the PSIP payments are "unfair", the low reimbursement rates are a result of limited available PSIP funding and the increased number/dollar amount of claims.

PSIP reimbursement rates could increase if more patients paid for their own medical care. This could be achieved by having physicians offer to settle accounts with patients for less than the full charge before billing PSIP, or by DHS attempting to collect from PSIP patients using outside collections agencies.

DHS can improve the efficiency of the current PSIP physician payment process by allowing physicians to enroll for multiple years, instead of annually; expediting payments by establishing reimbursement rates earlier, using a lower interim rate or using claim information from earlier years; and obtaining delegated authority to change rates without Board approval.

In addition, we noted that DHS needs to document its administrative costs for some funding sources and consider paying for additional audits of PSIP claims.

**Program Transparency**

Our review indicates that DHS meets expectations for PSIP program transparency. Specifically, State law requires DHS to obtain physician and hospital input on PSIP claims processing. To address this, DHS established the Physician Reimbursement Advisory Committee (PRAC) to advise them on PSIP issues and make recommendations on physician reimbursement policies and rates. DHS indicated that all PRAC meetings and decisions are open to the public.

In addition, DHS' EMS Agency sends "Information Bulletins" on current PSIP matters to physicians and posts them on DHS' website. DHS indicated that they also inform the Board of significant PSIP issues, including rate changes. To further increase transparency, we have recommended that DHS submit semiannual status reports to the Board with current PSIP information.

**Preserving the Emergency Care Safety Net**

Preserving emergency care, especially in underserved areas, is a significant challenge. Low reimbursement rates may reduce the availability and quality of emergency services. Hospitals that rely on PSIP funding to provide additional compensation to emergency physicians may have trouble getting adequate physician coverage, or may have to close their emergency departments. This could force patients in some areas to travel farther, and wait longer, to receive care.

We noted that State law prevents DHS from using PSIP's largest funding source (Senate Bill 612/1773) to give preferential treatment to any facility or physician. This funding source requires DHS to pay physicians equally, regardless of where they work. As a result, DHS cannot target these funds to the most vulnerable areas. However, we noted that funds from the Measure B special tax, which voters approved in 2002, can be used without restrictions. In addition, State law allows the County to use South Los Angeles Medical Services Preservation Fund (South LA) money to pay physician claims from hospitals impacted by the closure of Martin Luther King, Jr. – Harbor Hospital (MLK).

DHS currently uses Measure B and South LA funds to pay claims from those impacted hospitals at the same reimbursement rate as claims from other areas (i.e., these funds benefit all physicians equally). However, DHS could provide a higher reimbursement rate for physicians in that underserved area by paying their claims with the other PSIP funds at the normal rate, and using Measure B and South LA funds to supplement the payment. We have recommended that DHS management further evaluate using Measure B and South LA funds to directly benefit physicians at impacted hospitals, and pay physicians accordingly.

**Health Care Reform**

In March 2010, the federal Patient Protection and Affordable Care Act (Act) was passed. The Act is intended to provide a majority of the uninsured population with access to health insurance. If the Act is implemented, it could result in more patients with third-party coverage, which would reduce the number of PSIP claims, and allow DHS to increase PSIP reimbursement rates. However, it is unclear how much of the Act will be implemented, or whether the State will change the PSIP program based on the federal program. In addition, while PSIP may not be needed to maintain the emergency care safety net at the current level, it will probably continue to be needed in some form because some individuals will not have third-party health coverage.

Details of the results of our review are attached.

## Review of Report

We discussed the results of our review with DHS, County Counsel, the EMS Commission, the County's Hospitals and Health Care Delivery Commission, and PRAC. These parties generally agreed with our findings and recommendations, and their responses to our report are attached.

DHS' response indicates they disagree with our recommendation regarding evaluating the use of Measure B and South LA funds to directly benefit physicians at impacted hospitals. DHS indicated that reducing the reimbursement rate for other physicians would create a disincentive to work at non-impacted hospitals, which could close emergency rooms and destabilize the emergency care network. DHS' response indicates that they have initiated or taken corrective action to address our other recommendations. The Auditor-Controller will be available to assist DHS in implementing the recommendations, if needed.

We thank DHS, County Counsel and the various commissions and committees for their cooperation and assistance during our review. Please call me if you have any questions, or your staff may contact Jim Schneiderman at (213) 253-0101.

WLW:MMO:JLS:mwm

Attachments

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Emergency Medical Services Commission
Los Angeles County Hospitals and Health Care Delivery Commission
Physician Reimbursement Advisory Committee
Audit Committee
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# DEPARTMENT OF HEALTH SERVICES
# PHYSICIAN SERVICES FOR INDIGENTS PROGRAM REVIEW

At the February 16, 2010 meeting, the Board of Supervisors (Board) instructed the Auditor-Controller (A-C), in consultation with affected department heads, County Counsel, the Emergency Medical Services (EMS) Commission, the Hospitals and Health Care Delivery Commission, and the Physician Reimbursement Advisory Committee (PRAC), to conduct a policy and operational review of the Department of Health Services' (DHS) Physician Services for Indigents Program (PSIP or Program).

DHS established PSIP in 1987 to reimburse non-County physicians for emergency medical services provided to indigent patients at non-County hospitals who do not have third-party health coverage and who do not pay their own bill. DHS' EMS Agency administers PSIP.

As part of the review, the Board instructed the A-C to conduct a policy and operational review of the PSIP program, specifically in the areas of: 1) DHS paying physicians promptly, fairly and efficiently; 2) maintaining PSIP transparency in policy-making and management; and 3) preserving and protecting the County's emergency care safety net. Our review also addresses the concerns of the parties noted above, and includes our findings and recommendations for improving the Program.

## Background

PSIP pays physicians a percentage of Official County Fee Schedule rates for services they provided to indigent patients. On February 16, 2010, the Board reduced the Fiscal Year (FY) 2009-10 PSIP emergency services reimbursement rate from 27% of the Official County Fee Schedule to 18%. The decrease was primarily due to the State eliminating $8.8 million in Emergency Medical Services Appropriation (EMSA) funding (approximately 30% of total PSIP funding), and because of increases in the number of physicians enrolled in PSIP and the number of claims for services to indigent patients. DHS decreased the PSIP reimbursement rate to ensure that sufficient funds would be available to pay all projected FY 2009-10 claims.

## Scope

We reviewed PSIP funding sources and uses, physician enrollment and claim procedures, and DHS' method of establishing reimbursement rates. We also looked at potential ways to increase the PSIP reimbursement rates, reviewed DHS' audits of PSIP claims, examined Program transparency, and considered the effects of PSIP on the emergency care safety net. In addition, we briefly evaluated the potential impact of recently passed federal health care reform on the Program.

Throughout the review, we continuously met with DHS management, and representatives from the EMS Commission and PRAC. We also interviewed executives

from American Insurance Administrators (AIA) and MedAmerica, Inc. AIA is the PSIP third-party claims administrator, and is responsible for processing physician enrollment and claims. MedAmerica is a prominent billing agent representing physician groups, including many enrolled in the Program. In addition, we attended various commission meetings, and contacted health agencies from other counties to discuss their physician indigent care reimbursement programs.

## Program Funding

DHS' estimated FY 2009-10 PSIP budget was approximately $22.0 million. Funding sources included:

- **State Authorized Court Penalties (Senate Bill (SB) 612 and SB 1773)** – Approximately $16.1 million (including interest). State law allows the County to charge additional penalties on some court fines to pay physicians and hospitals for emergency and trauma services for indigents. The County can also use part of the funds for other emergency medical service purposes.

- **Los Angeles County Measure B** – Approximately $4.7 million. Voter approved special tax on improved property to fund the County trauma center system, emergency medical services and bioterrorism response.

- **South Los Angeles Medical Services Preservation Fund** – Approximately $1.2 million. State funding to support health services to the uninsured population in South Los Angeles due to the closure of Martin Luther King, Jr. – Harbor Hospital (MLK).

In prior years, the State also provided PSIP funding through the California Healthcare for Indigents Program (CHIP) and EMSA. CHIP and EMSA were established as a result of a voter approved tobacco tax that required the State to use some of the revenue to pay physicians for uncompensated health services for indigents. The following is a comparison of PSIP program funding levels for the last three years:

**PSIP PROGRAM FUNDING SOURCES – COMPARISON OF ANNUAL FUNDING LEVELS**

| | FY 2007-08 | FY 2008-09 | FY 2009-10[1] |
|---|---|---|---|
| STATE FUNDING SOURCES: | | | |
| California Healthcare for Indigents Program (CHIP) | $ 122,656 | $ - | $ - |
| Emergency Medical Services Appropriation (EMSA) | 8,801,275 | 8,801,277 | - |
| South Los Angeles Medical Services Preservation Fund | 1,063,325 | 1,215,228 | 1,215,228 |
| TOTAL STATE FUNDING SOURCES | $ 9,987,256 | $ 10,016,505 | $ 1,215,228 |
| COUNTY FUNDING SOURCES: | | | |
| Senate Bill 612 (Maddy) | $ 9,535,542 | $ 8,271,763 | $ 8,802,253 |
| Senate Bill 1773 (Alarcón) | 6,457,918 | 6,338,189 | 7,017,371 |
| Los Angeles County Measure B: Preservation of Trauma Centers and Emergency Medical Services; Bioterrorism Response (November 2002) | 4,716,000 | 4,716,000 | 4,716,000 |
| TOTAL COUNTY FUNDING SOURCES | $ 20,709,460 | $ 19,325,952 | $ 20,535,624 |
| INTEREST REVENUE: | $ 350,392 | $ 286,806 | $ 285,000 |
| **TOTAL PSIP PROGRAM FUNDING:** | **$ 31,047,108** | **$ 29,629,263** | **$ 22,035,852** |
| EMERGENCY SERVICES REIMBURSEMENT RATE | 29% | 27% | 18% |
| TRAUMA REIMBURSEMENT RATE | 50% | 50% | 50% |

[1] *Estimated Actuals. Actual collection data only available as of February 2010.*

As indicated in the chart, PSIP funding has decreased by approximately $9 million, from $31 million in FY 2007-08 to $22 million in FY 2009-10. The decrease was primarily due to the State eliminating CHIP and EMSA funding. In order to increase PSIP funding and payments to physicians, DHS should continue to work with the Board and Chief Executive Office (CEO) to support the efforts of physician organizations, hospital associations, other counties, and business and labor organizations to restore, or replace, State CHIP and EMSA funding.

DHS also showed a $1.4 million decrease in County funding, from $20.7 million in FY 2007-08 to $19.3 million in FY 2008-09, because DHS only used eleven months of SB 612/SB1773 collections to fund the Program that year. DHS reclassified the last month's collections for the year as the first month's collections for the following fiscal year. DHS management should ensure that PSIP funding is based on 12 months of collections.

## Recommendations

**DHS management:**

1. **Continue to work with the Board and CEO to support the efforts of physician organizations, hospital associations, other counties, and business and labor organizations to restore, or replace, State CHIP and EMSA funding.**

2. **Ensure PSIP funding is based on 12 months of collections.**

## Funding Sources

At the time of our review, DHS indicated that the Department's FY 2009-10 budget had an overall shortfall of over $200 million. In addition, Department management indicated they were not aware of any other potential funding sources for PSIP. We reviewed the current funding sources to identify any additional funding available, and noted the following:

### SB 612 and SB 1773

As discussed earlier, SB 612/1773 provide funding for emergency and trauma services from additional penalties for some court fines and motor vehicle violations. The courts collected approximately $30.4 million in SB 612/1773 funds in FY 2008-09. DHS distributes the funds to PSIP, hospitals that provide disproportionate trauma and emergency medical services, pediatric trauma centers and for other emergency medical services. We verified that the courts correctly assess the penalties and DHS appropriately distributes the funds according to State law.

DHS is allowed to use up to 10% of SB 612/1773 funding to pay for its SB 612/1773 administrative costs. We noted that DHS allocates the full 10% for administrative cost ($3.1 million) to their EMS Agency. However, DHS does not document their actual SB 612/1773 administrative costs. DHS management should document their actual SB 612/1773 administrative costs, and verify that SB 612/1773 funds are only used to pay for documented costs.

#### Recommendation

3. **DHS management document their actual SB 612/1773 administrative costs, and verify that SB 612/1773 funds are only used to pay for documented costs.**

### Measure B

In November 2002, County voters approved Measure B authorizing a special tax on improved property to fund the County trauma center system, emergency medical services and bioterrorism response. We verified that DHS used Measure B funding for appropriate purposes and that no additional funds were available.

### South Los Angeles Medical Services Preservation Fund

In October 2007, the State established the South Los Angeles Medical Services Preservation Fund (South LA) to support health services to the uninsured population of South Los Angeles due to the closure of MLK. DHS received $90 million in South LA funding during FY 2009-10 and used approximately $1.2 million for PSIP emergency claims. We verified that DHS allocated the remaining $88.8 million of South LA funding for appropriate purposes and that no additional funds were available.

## Emergency Care Safety Net

Low reimbursement rates could affect the availability and quality of emergency services in the County. Hospitals that rely on PSIP funding to provide additional compensation for emergency staff may experience inadequate physician coverage or have to close emergency departments altogether. This could significantly impact patients in some areas, who would have to travel farther, and wait longer, to receive care.

We noted that State law restricts DHS from using SB 612/1773 funds to give preferential treatment to any facility or physician. DHS must also pay physicians fairly, without preference, if they do not have enough funding to pay all claims at the maximum rate. As a result, DHS cannot target SB 612/1773 funds to the most vulnerable areas.

The County can use Measure B funds without restriction and South LA funds to pay physician claims from hospitals impacted by the closure of MLK. DHS currently uses Measure B and South LA funds to pay claims from these impacted hospitals at the same reimbursement rate as claims from other areas. When Measure B and South LA funds are exhausted, DHS uses SB 612/1773 funds to pay the remaining claims. Even though Measure B and South LA are used to pay physicians at impacted hospitals, the funds benefit all PSIP physicians equally. A comparison of funding sources and uses is as follows:

**COMPARISON OF FUNDING SOURCES AND FUNDING USES**
**FY 2007-2008**

| | CHIP, EMSA, SB 612, SB 1773, INTEREST | LOS ANGELES COUNTY MEASURE B | SOUTH LA PRESERVATION FUND | TOTAL |
|---|---|---|---|---|
| FUNDING SOURCES: | | | | |
| Collections | $ 25,267,783 | $ 4,716,000 | $ 1,063,325 | $ 31,047,108 |
| Refunds from Previously Paid Claims | 490,800 | - | - | 490,800 |
| TOTAL FUNDING SOURCES | $ 25,758,583 | $ 4,716,000 | $ 1,063,325 | $ 31,537,908 |
| FUNDING USES: | | | | |
| Emergency Claims - General | $ 24,763,025 | $ - | $ - | $ 24,763,025 |
| Emergency Claims - St. Francis Medical Center | 101,012 | 777,613 | *[2]* | 878,625 |
| Emergency Claims - Other Impacted Hospitals | *[1]* | - | 1,063,325 | 1,063,325 |
| Trauma Claims | 663,740 | 3,938,387 | - | 4,602,127 |
| TOTAL FUNDING USES | $ 25,527,777 | $ 4,716,000 | $ 1,063,325 | $ 31,307,102 |
| SURPLUS/(DEFICIT): | $ 230,806 | $ - | $ - | $ 230,806 |

*[1] The data DHS provided did not specify the portion of funding used to pay emergency claims at other impacted hospitals. These claims are grouped together with general emergency claims.*

*[2] The data DHS provided did not specify the portion of funding used to pay emergency claims at St. Francis Medical Center. These claims are grouped together with other impacted hospital emergency claims.*

DHS could provide a higher reimbursement for physicians at impacted hospitals by paying their claims with SB 612/1773 funds at the normal PSIP rate, and then using Measure B and South LA to supplement the payment (e.g., pay them a higher rate, make an additional year-end payment, etc.). Based on current funding and claim

information, physicians would be paid 23% for services at impacted hospitals and 15% for services at all other hospitals.

**Recommendation**

4. **DHS management further evaluate the feasibility of using Measure B and South LA funds that are allocated to PSIP to directly benefit physicians at impacted hospitals, and pay physicians accordingly.**

## PSIP Physician Enrollment Process

DHS sends PSIP enrollment packets to physicians each year after the Board has approved the reimbursement rate. FY 2009-10 enrollment packets were sent in February 2010. Enrollment packets include the current PSIP policy, provider enrollment form, and a participation agreement. Physicians must complete the enrollment documents before AIA will process claims, and must resubmit documents if information changes (i.e., hospital, billing address, etc.). Approximately 4,600 physicians were enrolled in the Program as of November 2010.

Physician representatives from the EMS Commission, County's Hospitals and Health Care Delivery Commission and PRAC indicated that PSIP physicians generally believe the annual enrollment process is time consuming, and delays claim submission and payment. We also noted that other counties do not require physicians to enroll annually. DHS management should consider implementing a multi-year enrollment policy (e.g., biennial enrollment, etc.). Physicians would need to submit enrollment documents to initially enroll in PSIP and during specified reenrollment periods. In addition, physicians will still be responsible for updating their information on file, and AIA will continue to deny claims that conflict with their records.

**Recommendation**

5. **DHS management consider implementing a multi-year PSIP enrollment policy (e.g., biennial enrollment, etc.).**

## Reimbursement Rates and Physician Claims

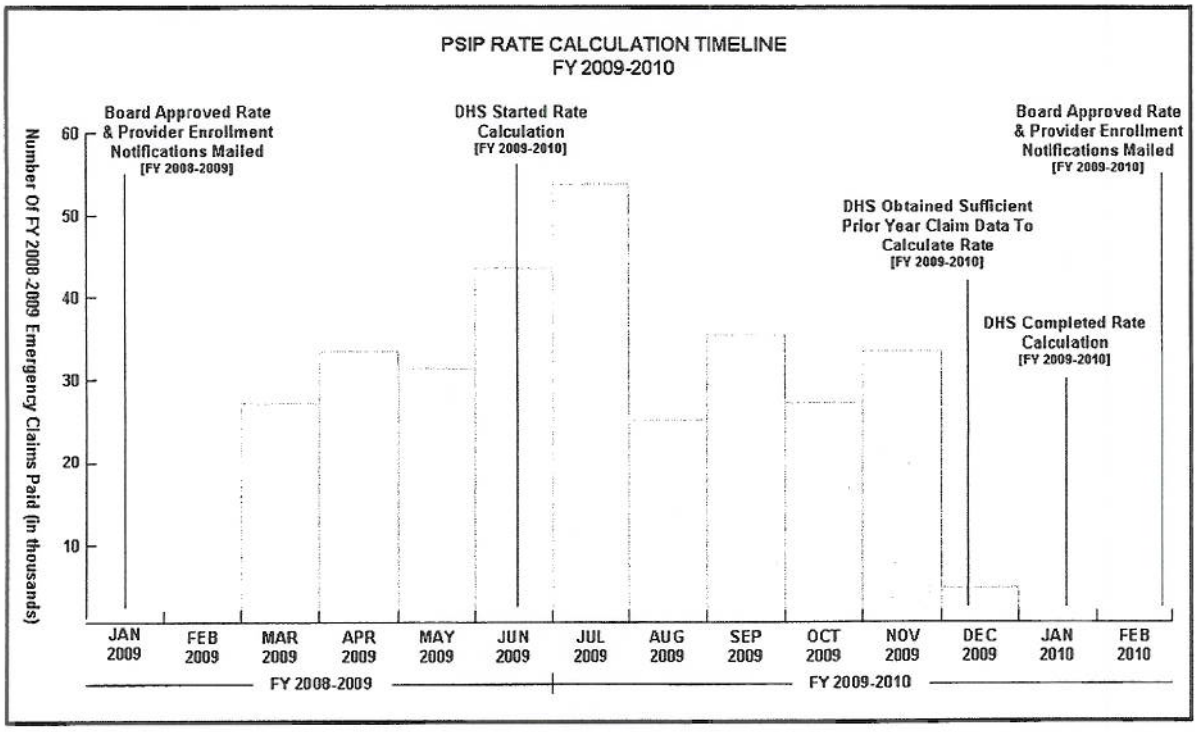
Once DHS establishes the reimbursement rate and the Board approves the rate, physicians may enroll in the Program and submit claims. Physicians must bill the patients and make a reasonable effort to collect from the patients for three months following the initial bill, before submitting a claim to PSIP. AIA pays claims using the approved reimbursement rate. We reviewed DHS' method of establishing reimbursement rates and AIA's claims processing procedures, and noted the following:

## Method of Establishing Reimbursement Rates

DHS establishes the PSIP reimbursement rate by comparing estimated annual total PSIP funding to estimated total claims at different potential rates. DHS develops their estimates using funding and claim information from the most recent year. While Measure B and South LA funds are approximately the same each year, SB 612/1773 funds and PSIP claims vary annually.

## Reimbursement Rate Delays

As noted earlier, the FY 2009-10 PSIP reimbursement rate was not approved by the Board until February 2010, over half-way through the year. This delayed when physicians could submit claims and delayed payment of the claims. The delay in establishing the reimbursement rate was due to DHS not having enough prior year claim information to estimate current year claims. As a result, a delay in one year will cause similar delays in future years. The following timeline highlights the amount of prior year claim information DHS received each month and the resulting delay in establishing the reimbursement rate:




DHS can reduce delays in setting the reimbursement rates and accepting claims by obtaining enough claim information before the following year or by using claim information from prior fiscal years. DHS can further reduce delays if the Board gives them delegated authority to approve reimbursement rate changes.

- **Obtaining claim information** – To obtain enough claim information, DHS needs to allow physicians to submit claims earlier in the year, and establish deadlines for submitting claims based on service dates. However, as discussed earlier, physicians cannot currently submit claims early in the year because reimbursement rates are established months later. DHS could initially pay physicians a provisional low rate at the beginning of a year, so they can submit claims, and DHS could reimburse physicians later for the difference between the provisional rate and final rate. While AIA would charge DHS approximately $40,000 to change rates during the year, DHS would only incur the costs once since they should be able to calculate rates earlier in future years.

- **Using claim information from earlier years** – As noted, DHS currently uses claim information from the most recent prior year to calculate reimbursement rates. Instead of using a lower provisional rate as discussed above, DHS could also establish rates at the beginning of the fiscal year by using claim information from earlier years. While this would eliminate having to update the provisional rate to a final rate, the rate that is developed using this approach may not be as accurate, which increases the risk that there will not be enough money available to pay all claims.

- **Delegated authority** – The Board should consider giving DHS delegated authority to approve reimbursement rate changes. Board approval of the rates does not appear to be necessary since rate calculations are based entirely on estimated available funding and projected payments (e.g., rates must decrease when payments exceed available funding, etc.). DHS would still inform the Board of rate changes annually, as currently required.

While these changes will allow physicians to submit claims and receive payments earlier, they still might not be paid until November. This is because DHS does not make payments until they receive their September SB 612/1773 collections, and the funds are not transferred to PSIP until November. DHS started this process after using fifteen months of collections to fund PSIP during FY 2006-07. DHS indicated that they overestimated funding, and also wanted to match collections to the year the courts assessed penalties. To pay physicians before November, DHS would have to advance approximately $2.8 million to pay claims for July and August, and then start the next program year using July collections.

**Recommendations**

6. **DHS management consider implementing one of the following methods to establish reimbursement rates earlier:**

    - **Initially paying physicians a lower provisional reimbursement rate, and establishing deadlines for physicians to submit claims based on service dates.**

- **Calculating reimbursement rates using claim information from earlier fiscal years.**

7. **The Board consider giving DHS delegated authority to approve reimbursement rate changes.**

## Reimbursement Rate Comparison

The Board requested that we look at whether PSIP payments are "inherently unfair". We noted that PSIP physicians are currently paid an average of $48 per claim. This is substantially less than Medicare and Medi-Cal. For example, Medicare would have paid the physicians an average of $73 per claim. Medi-Cal also generally pays more than PSIP. While we cannot assess whether the PSIP payments are "unfair", the low reimbursement rates are a result of limited available PSIP funding and the increased number/dollar amount of claims.

## Claim Submission Process

The Board also requested that we review the current claims process and determine whether a better process is available. Physicians submit claims using Current Procedural Terminology (CPT) codes, which identify the services/procedures provided by the physician. CPT codes are a standard coding system issued by the American Medical Association, and are used by other third-party payers (i.e., Medi-Cal, Medicare, etc.).

We discussed the current claim submission process with DHS, AIA, and MedAmerica. AIA indicated that they process electronic claims within 15 days and manual claims within 40 days. Approximately 80% of claims are sent electronically. DHS pays AIA approximately $1.60 and $3.00 to process each electronic and manual claim, respectively. We were not able to identify the average cost for physicians to submit claims because the information is proprietary. However, all parties indicated that physicians and billing agents are generally satisfied with the current claim submission process, and that changing the process may cause confusion.

## Increasing Reimbursement Rates

As indicated earlier, State budget cuts and increases in the number of emergency claims have significantly reduced PSIP physician reimbursement rates. PSIP reimbursement rates could increase if more patients paid for their own medical care. This could be achieved by having physicians offer to settle accounts with patients for less than the full charge before billing PSIP, or by DHS attempting to collect from PSIP patients using outside collections agencies. These measures could increase the funding available to pay other PSIP claims.

## Reduced Settlement

PSIP and the State Health and Safety Code require physicians to try to collect from patients for three months, before submitting a claim to PSIP. Physicians are supposed to send two bills to the patients during the three months, but can immediately submit claims to PSIP if they are notified that the patient will not pay.

We noted that physicians bill patients an average of $441 for each claim, compared to the $48 they receive from PSIP. Given the difference between the amount billed and the amount PSIP pays, physicians may be able to increase their collections by billing patients a reduced settlement amount, at least as much as what PSIP would pay, before submitting the claims to PSIP. The reduced settlement amount could be included on the second bill. This should encourage patients to pay physicians more than they would receive from PSIP, and increase available funding for PSIP claims. We estimate that PSIP reimbursement rates will increase by one percentage point for every five percent increase in PSIP claims paid by patients.

### Recommendation

8. **DHS management consider requiring physicians to bill patients a reduced settlement amount, at least as much as what PSIP would pay, before submitting claims to PSIP.**

## Collection Agencies

To participate in the Program, physicians must agree to stop their collection efforts against patients, or responsible third-parties, after they are paid by PSIP, and assign their collection rights to the County. However, the County is allowed to try and collect the full amount billed by the physician, regardless of how much PSIP paid the physician. Physicians are also supposed to cooperate with the County's collection efforts.

We noted that DHS does not try to collect anything from PSIP patients. DHS should consider using their contract collection agencies to collect up to the full amount billed by physicians from PSIP patients or responsible third-parties. This could increase available funding for PSIP claims. Since collection agencies are paid a percentage of the amounts collected, there would be no additional cost to the County, except for incremental administrative costs. DHS indicated that their collection agencies generally collect approximately 5% of all amounts referred. Any net proceeds received from collection agencies should be used for PSIP.

### Recommendation

9. **DHS management consider using collection agencies to collect up to the full amount billed by physicians from patients or responsible third-parties.**

## Physician Audits

DHS' EMS Agency plans to audit PSIP claims every year. However, these audits have been delayed because EMS' audit staff left the Agency and have not yet been replaced. The last audit the Agency completed covered FY 2006-07 claims. Due to limited staffing, the Agency selected a judgmental sample of 565 claims (less than 1% of total PSIP claims). They identified $730 in overpayments and are pursuing reimbursement.

Audits can discourage other physicians from committing similar errors and ensure physicians repay the County when they collect from other payers. In addition, the EMS Agency indicated that they conduct workshops to educate billing agents on program requirements, potential County audits, and refund requirements. They also indicated that refunds to the County have increased as a result of the audits and workshops. DHS should identify whether any additional funding is available to audit PSIP claims, and consider using the funds to either hire additional audit staff or contract for audit services. DHS should also consider reassigning existing County staff to complete the audits.

### Recommendation

**10. DHS management identify whether any additional funding is available for auditing PSIP claims, and consider using the funds to either hire additional staff or contract for audit services. The reassignment of existing County staff should also be considered.**

## Program Transparency

The State Health and Safety Code requires DHS to obtain physician and hospital input on the PSIP claims process to ensure payments are fair and timely. As a result, DHS established the PRAC to advise them on PSIP issues and make recommendations on physician reimbursement policies and rates. Although County Counsel determined that PRAC is not subject to Brown Act requirements, DHS indicated that all PRAC meetings and decisions are open to the public.

In addition, DHS indicated that the EMS Agency sends "Information Bulletins" on current PSIP matters to physicians and posts them on DHS' website. DHS also indicated that they inform the Board of significant PSIP issues, including rate changes. To further ensure PSIP information is publicly available, DHS should submit semiannual status reports to the Board with current PSIP information (e.g., available funding, number of enrolled physicians, number and dollar amount of claims, PRAC recommendations and meeting results, etc.). These reports should also include any emerging trends in PSIP, identify any emergency service access or quality issues that may arise, and report the accomplishments and problems of the Program.

**Recommendation**

**11. DHS management submit semiannual status reports to the Board on PSIP information.**

## Health Care Reform

In March 2010, the federal Patient Protection and Affordable Care Act (Act) was passed, which is intended to provide a majority of the uninsured population with access to health coverage. This could result in more patients with third-party coverage, which would reduce the number of PSIP claims, allowing for increased PSIP reimbursement rates. However, it is unclear how much of the Act will be implemented, or whether the State will change the PSIP program based on the federal program. In addition, while PSIP may not be needed to maintain the emergency care safety net at the current level, it will probably continue to be needed in some form because some individuals will not have third-party health coverage.

Health Services
LOS ANGELES COUNTY

December 14, 2010



TO: Wendy L. Watanabe
Auditor-Controller

FROM: John F. Schunhoff, Ph.D.
Interim Director

SUBJECT: **DEPARTMENT OF HEALTH SERVICES - PHYSICIAN SERVICES FOR INDIGENTS PROGRAM (PSIP)**



Attached is the Department of Health Services' response to the recommendations made in the Auditor-Controller's report of its review of PSIP. We concur with most of the recommendations contained in the report and have initiated or taken corrective actions to address the recommendations.

If you have any questions or require additional information, please let me know or you may contact Sharon Ryzak at (213) 240-7901.

JFS:sr

Attachment

c: Cathy Chidester
Efrain Munoz
Gregory C. Polk
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*To improve health through leadership, service and education*

**COUNTY OF LOS ANGELES – DEPARTMENT OF HEALTH SERVICES**

**RESPONSE TO AUDITOR-CONTROLLER DEPARTMENT OF HEALTH SERVICES (DHS) PHYSICIANS SERVICES FOR INDIGENT PROGRAM (PSIP) REVIEW –**

AUDITOR-CONTROLLER RECOMMENDATION #1

DHS management continue to work with the Board of Supervisors (Board) and Chief Executive Office (CEO) to support the efforts of physician organizations, hospital associations, other counties, and business and labor organizations to restore, or replace State California Healthcare for Indigents Program (CHIP) and Emergency Medical Services Appropriation (EMSA) funding.

**DHS response:**

We agree. DHS management will continue our efforts to encourage the State to restore the EMSA fund and support physician organizations such as California American College of Emergency Physicians (CalACEP), hospital associations, other counties, and business and labor organizations to pursue legislation to increase funding for physician reimbursement.

AUDITOR-CONTROLLER RECOMMENDATION #2

DHS management ensure PSIP funding is based on 12 months of collections.

**DHS response:**

We agree. Funding for the program is currently and will continue to be based on 12 months of collections.

AUDITOR-CONTROLLER RECOMMENDATION #3

DHS management document their actual Senate Bill (SB) 612/1773 administrative costs, and verify that SB 612/1773 funds are only used to pay for documented costs.

**DHS response:**

We agree. DHS/Emergency Medical Services (EMS) will document actual administrative costs associated with the SB 612/1773 funds and verify that SB 612/1773 funds are used to cover documented costs only.

AUDITOR-CONTROLLER RECOMMENDATION #4

DHS management further evaluate the feasibility of using Measure B and South Los Angeles Medical Services Preservation (South LA) Funds that are allocated to PSIP to directly benefit physicians at impacted hospitals, and pay physicians accordingly.

**DHS response**

We disagree. Implementing this recommendation will reduce the reimbursement rate for physicians working at non-Impacted Hospital Program (IHP) hospitals and may create a disincentive for physicians to work at these facilities with a large uninsured population. This could lead to closure of emergency rooms and could destabilize the fragile LA County Emergency Care Network. In addition, the Physician Reimbursement Advisory Committee (PRAC) is opposed to further reduction of the reimbursement rate.

AUDITOR-CONTROLLER RECOMMENDATION #5

DHS management consider implementing a multi-year enrollment policy (e.g., biennial enrollment, etc.).

**DHS response:**

We agree. DHS management will request Board approval to implement a three-year enrollment beginning with Fiscal Year 2010-2011.

AUDITOR-CONTROLLER RECOMMENDATION #6

DHS management consider implementing one of the following methods to establish reimbursement rates earlier:

- Initially pay physicians a provisional low reimbursement rate and establish deadlines for physicians to submit claims based on service dates.
- Calculate reimbursement rates using claim information from earlier fiscal years.

**DHS response:**

We agree. Due to the cost associated with processing multiple payments, DHS will continue to implement the PSIP reimbursement rate based on projected revenues and expenditures using claims, statistical, and revenue collection data from the previous fiscal years.

AUDITOR-CONTROLLER RECOMMENDATION #7

The Board consider giving DHS delegated authority to approve reimbursement rate changes.

**DHS response:**

We agree. Since the PSIP reimbursement rate is solely based on projected revenues and claims expenditures, DHS will request delegated authority from the Board to establish and approve the rate beginning with Fiscal Year 2011-2012.

AUDITOR-CONTROLLER RECOMMENDATION #8

DHS management consider requiring physicians to bill patients a reduced settlement amount, at least as much as what PSIP would pay, before submitting PSIP claims.

**DHS response:**

We agree. Effective Fiscal Year 2010-2011, DHS management will include a requirement in the PSIP Billing Procedures that physicians bill patients a reduced settlement amount, at least as much as what PSIP would pay, before submitting PSIP claims.

AUDITOR-CONTROLLER RECOMMENDATION #9

DHS management consider using collection agencies to collect up to the full amount billed by physicians from patients or responsible third-parties.

**DHS response:**

We agree. DHS management will evaluate assigning the paid claims to the collection agency to pursue collection of up to the full charges from patients or other third-parties for services provided by PSIP participating physicians. Implementation of this recommendation will require an amendment to the current contract which does not cover collection for services provided at non-County facilities.

AUDITOR-CONTROLLER RECOMMENDATION #10

DHS management identify whether any additional funding is available for auditing PSIP claims, and consider using the funds to either hire additional staff or contract for audit services. The reassignment of existing County staff should also be considered.

**DHS response:**

We agree. DHS will evaluate the availability of any existing funding, consider using the funds to either hire additional staff or contract for audit services, and also evaluate reassigning existing County staff.

AUDITOR-CONTROLLER RECOMMENDATION #11

DHS management submit semiannual status reports to the Board on PSIP information.

**DHS response:**

We agree. Effective January 2011, DHS/EMS will develop a semi-annual PSIP status report to the Board.

# COUNTY OF LOS ANGELES
# EMERGENCY MEDICAL SERVICES COMMISSION

10100 Pioneer Boulevard, Suite 200, Santa Fe Springs, CA 90670
(562) 347-1641 FAX (562) 941-5835

November 22, 2010

TO: Wendy L. Watanabe
Auditor-Controller, Los Angeles County

FROM: David Austin, Vice Chairman
Los Angeles County EMS Commission

SUBJECT: **PHYSICIAN SERVICES FOR INDIGENTS PROGRAM**

At its November 17, 2010 meeting, the Los Angeles County Emergency Medical Services Commission, in consultation with your PSIP review team, considered each of the eleven recommendations in the September 20, 2010 draft report on the review of the PSIP program.

Based on that discussion, attached is Emergency Medical Services Commission's response.

PSIP is an important strand in the County's emergency care safety net which serves us all. Please accept the Commission's thanks for the good work the Office of Auditor-Controller is doing to help maintain its integrity.

DA:mr

Attachment

c: Interim Director of Health Services
Director, Los Angeles County EMS Agency
Each Member, Physician Reimbursement Advisory Committee
Chair, Los Angeles County Hospitals and Health Care Delivery Commission

Emergency Medical Services Commission's response to the
Department of Auditor-Controller's Recommendations to the Board of Supervisors on
Physician Services for Indigents Program (PSIP)

1. **DHS Management continue to work with the Board and CEO to support any physician organizations' efforts to restore or replace State CHIP and EMSA funding.**
*CONCUR WITH MODIFICATION. In addition to physicians' groups, DHS' and CEO's coalition-building efforts to restore State PSIP funding as the economy improves should include interested constituencies such as other counties, hospital associations, business and labor organizations, etc.*

2. **DHS management ensure PSIP funding is based on 12 months of collections.**

*CONCUR WITH MODIFICATION. Also determine the root cause as to why only eleven months rather than the full twelve months of SB 612/1773 funding was made available to PSIP in FY 2008-09. Institute measures to prevent any repetition. Auditor-Controller should remain available to assist DHS in implementation.*

3. **DHS management document their actual SB 612/1773 administrative costs, and verify that SB 612/1773 funds are only used to pay for documented costs.**

*CONCUR. Auditor-Controller should remain available to assist DHS in implementation.*

4. **DHS management further evaluate the feasibility of using Measure B and South LA funds that are allocated to PSIP to directly benefit physicians at impacted hospitals, and pay physicians accordingly.**

*CONCUR IN PART AND WITH MODIFICATION. The feasibility of using measure B and South L.A. funds to maintain services at impacted hospitals should be explored, and contingency plans for rapid implementation developed if and when need arises. The scope of the feasibility study should also include possible methods which would meet the "no prefential treatment" test in law for use of SB 612/1773 funds whiles serving the practical purpose of improved reimbursement to physicians who dispropotionately treat the uninsured. Auditor-Controller should remain available to assist DHS in studying feasibility and developing contingency plans. No such plans should be implemented without indicated need and an open, transparent decision-making process.*

5. **DHS management consider implementing a multi-year enrollment policy (e.g., biennial enrollment, etc.).**

*CONCUR WITH MODIFICATION. Re-enrollment of actively participating physicians should not be required at all absent good reason; and where necessary, should be streamlined. Auditor-Controller should remain available to assist DHS in implementation.*

6. **DHS management consider implementing one of the following methods to establish reimbursement rates earlier: a) Initially pay physicians a provisional low reimbursement rate and establish deadlines for physicians to submit claims based on service dates; or b) Calculate reimbursement rates using claim information from earlier fiscal years.**

*CONCUR WITH MODIFICATION. A combination of both methods may be appropriate. The process of rate development and review should be scheduled, systematic and highly transparent. DHS with CEO should also identify from existing County funds, the $2.8 million in one-time funding required to finance the acceleration of claims payments. Auditor-Controller should remain available to assist DHS in implementation.*

7. **The Board consider giving DHS delegated authority to approve reimbursement rate changes.**

*CONCUR WITH MODIFICATION. Delegation should be considered as a part of the implementation plan for recommendation #6 as modified above. Delegation should be allowed once a systematic, highly open public process for rate development has been adopted as an alternative to the Board approval process. This transparency process should include ample and clear advance notice to the Board of scheduled public hearings on rates and on scheduled implementation of rate changes. This transparency process should also clarify and fully coordinate the respective advisory and review roles of the Emergency Medical Services Commission, the Physician Reimbursement Advisory Committee, and any other County body which has or should have an ongoing PSIP advisory or review role. Auditor-Controller should remain available to assist DHS in implementation.*

8. **DHS management consider requiring physicians to bill patients a reduced settlement amount (i.e., percentage of initial bill, etc.) before submitting PSIP claims.**

*CONCUR WITH MODIFICATION. It is suggested that the recommendation read, "DHS management consider development of methods which lead participating physicians to offer patients a settlement of account at an amount approximating the PSIP rate before submitting a PSIP claim." Auditor-Controller should remain available to assist DHS in implementation.*

9. **DHS management consider using collection agencies to collect the full amount billed by physicians from patients or responsible third-parties.**

*CONCUR WITH MODIFICATION. Consider inserting the words, "up to" after the word "collect." Policies and practices in implementing the collection program should be similar wherever appropriate to those used to attempt collection for the cost of County hospital care. Treasurer-Tax Collector should be made available to assist DHS in implementation of this program.*

10. **DHS management identify whether any additional funding is available for auditing PSIP claims, and consider using the funds to either hire additional staff or contract for audit services.**

*CONCUR WITH MODIFICATION. The potential to staff this function by reassignment of existing County staff should also be explored.*

11. **DHS management submit semiannual status reports to the Board on PSIP information.**

*CONCUR WITH MODIFICATION. Auditor-Controller should remain available to assist dhs in the project definition and design of the status reporting system. Such status reports should include reporting of emerging trends in the PSIP program, should flag any related emergency service access or quality issues which require attention and should candidly report both accomplishments and problems with improvement initiatives, including but not limited to those called for in this report.*

**ATTACHMENT IV**

Los Angeles County Board of Supervisors

RE: Physician Services for Indigent Patients (PSIP) program funding

Dear Supervisors,

We write regarding reimbursement rates for physicians providing services within the Physician Services for Indigent Patients (PSIP) program. These rates were reduced by 33 % in FY 2009-10, compared with FY 2008-9.

The FY 2009-10 reimbursement rates are critically low and are an enormous strain on any physician practice that sees significant numbers of indigent patients in Los Angeles County. For a typical mix of emergency physician or radiology services, the FY 2009-10 rates are around 36 % of Medicare rates. Because they are so low, these reimbursement rates create a strong incentive for physicians to limit their exposure to indigent patients in Los Angeles County. One consequence is insufficient availability of qualified specialists on call in Los Angeles County hospitals that see a significant number of these patients. Another consequence is that these hospitals are experiencing difficulty retaining physicians in their emergency medicine and radiology groups. This is because these groups are essentially being 'taxed' to provide care for indigent patients, by being required to provide their services at unsustainably low rates. The current rates therefore threaten the availability and quality of basic emergency medical services for all residents of Los Angeles County who visit an emergency room at a hospital which sees significant numbers of indigent patients.

We also raise the issue of whether Los Angeles County is acting responsibly toward to the physicians participating in the PSIP program. These physicians are a critical safety net, providing emergency health care to the neediest patients in Los Angeles County. It would never be reasonable for any physician to turn such patients away without basic emergency services. We submit it is also not reasonable for Los Angeles County to systematically require physicians to provide this care at unsustainable rates of reimbursement. Los Angeles County must have a responsibility not only to ensure that its neediest patients receive basic emergency care, but also to reasonably distribute the burden of the costs of providing these services amongst all its residents, rather than solely upon the physicians on the 'front-line'.

It would be therefore manifestly unjust to pass through reductions in PSIP funding directly to the physicians participating in the PSIP program. (The precipitous drop in PSIP reimbursement rates in FY 2009-10 was largely due to elimination of state funding sources for the program.) In the interests of the indigent patients of Los Angeles County, and all patients receiving care at hospitals participating in the PSIP program, and in the interests of fairness to the physicians participating in the PSIP program, we urge that you identify other County funds to replace State funding cuts. We further request that you identify long term revenue sources or funding to raise reimbursement rates to a level that is fair compensation for the services we provide.

Approved by unanimous vote of the physicians of the Physician Reimbursement Advisory Committee.